DIVISION OF PROFESSIONAL REGULATION
BD OF PHARMACY

APP/DATE_____ AMT_____ CK#_____

LIC/DATE_____ AMT_____ CK#_____

PERMIT #_____OTHER_____

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

TELEPHONE: (302) 744-4500
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BOARD OF PHARMACY

APPLICATION FOR PERMIT FOR NON-RESIDENT PHARMACY

No pharmacy located outside this State may ship, mail, or deliver in any manner, any controlled substance or prescription drug to a patient in this State unless first having obtained a permit from the Board of Pharmacy. Title 24 DEL. C. Chapter 25 must be followed when dispensing for Delaware clients.

This application must be accompanied with a non-refundable, pro-rated processing fee of $_____. Please refer to the Fee Schedule at www.dpr.delaware.gov for the correct fee.

(Please Print or Type)

Name of Pharmacy: _____

Address of Pharmacy: _____
(Include Street and number)

City, State & Zip: _____

Business Telephone (include area code): _____

Required Toll Free Number: _____
(According to 24 Del. C. §2540, this number shall appear on the label affixed to each container of drugs dispensed to patients in this State. Include sample label with this application.)

Sample of Label Included **Yes** ☐

Federal (DEA) Controlled Substances Registration Number: _____

State Controlled Substance Registration Number: _____

1. **If corporation, give date of charter, state of corporation and names and titles of all principal corporate officers:**

_____ _____
_____ _____
_____ _____
_____ _____

2. **List all unregistered employees (externs, technicians, clerks, aides, etc.)**

_____ _____
_____ _____
_____ _____
_____ _____

3. **If partnership, give names and titles of all active partners:**

_____ _____

_____ _____

4. **If individually owned, give name, address and phone number of owner:**

_____

_____

_____

5. **Each non-resident pharmacy shall designate a registered agent in Delaware for Service of Process. If no registered agent is named, then the Secretary of State of the State of Delaware shall be deemed the lawful representative.**

Registered Agent **Yes** ☐ **No** ☐

If yes, list name of Delaware Registered Agent: _____

Address: _____
(Include number and street)

City, State & Zip: _____

Phone Number of Registered Agent: _____

If Registered Agent is a Delaware pharmacist, please list Delaware Pharmacist and registration number:

_____

6. **List all pharmacists and their license number for the State in which this non-resident pharmacy is located who are dispensing prescription drugs or controlled substances to residents of this State (or attached list):**

Pharmacist-in-Charge: _____ **License #** _____

Staff Pharmacists:	**License #**	**Staff Pharmacists:**	**License #**
_____		_____	
_____		_____	
_____		_____	
_____		_____	

7. **I understand that I am responsible for conducting and managing the prescription department in compliance with applicable State and Federal laws.**

Signature _____ **Pharmacist-in-Charge**

8. **A report must be submitted within 30 days after any change of office, corporate officer, or pharmacist occurs.**

9. **The Board should also be notified about change of registered agent, change of name, change of address, discontinuation of business, or additional business sites.**

10. **Pharmacy Department Hours:**

Week days	_____**a.m.**	**to**	_____**p.m.**
Weekends Sat	_____**a.m.**	**to**	_____**p.m.**
Weekends Sun	_____**a.m.**	**to**	_____**p.m.**
Holidays	_____**a.m.**	**to**	_____**p.m.**

11. **According to 24 Del. C. §2540, a non-resident pharmacy agrees to not less than six (6) days per week, for a minimum of forty (40) hours per week. This requirement is met by above stated hours:**

Yes ☐ **No** ☐

12. **According to 24 Del. C. §2540, a non-resident pharmacy must maintain patient profiles in compliance with Delaware Board Regulations and must comply with the Delaware Drug Product Selection Act, 24 Del. C. §2553, and must provide pertinent patient medication information.**

Patient Profile Requirements: (Every item must be checked for compliance)

☐ **(1)** **Family name and first name of patient;**

☐ **(2)** **Address of patient and phone number or location in institution;**

☐ **(3)** **Patient's age or date of birth, and gender:**

☐ **(4)** **Original date of dispensing;**

☐ **(5)** **Number or designation for prescription;**

☐ **(6)** **Prescriber's name;**

☐ **(7)** **Name, strength and quantity of drug dispensed. Appropriate directions must also be present if medication is for patients in institutions;**

☐ **(8)** **Initials of dispensing pharmacist and date of dispensing medication as a refill if said initials and date are not recorded on original prescription;**

☐ **(9)** **If patient refuses to give all or part of the required information, the pharmacist shall indicate and initial in the appropriate area;**

☐ **(10)** **Record any allergies and idiosyncrasies of the patient and any chronic conditions or disease states and frequently use over-the-counter medication which may relate to drug utilization as communicated to the pharmacist by the patient. If the answer is none, this must be indicated on the profile.**

☐ **(11)** **Pharmacist comments relevant to the patient's drug therapy, including any other information peculiar to the specific patient or drug.**

☐ **(12)** **Upon receipt of a new prescription, a pharmacist must examine the patient's profile record before dispensing the medication to determine the possibility of a harmful drug interaction or reaction. Upon recognizing a potential harmful reaction or interaction, the pharmacist shall take appropriate action to avoid or minimize the problem which shall if necessary, include consultation with the physician. In addition, with each new medication dispensed, an offer to counsel must be provided to the patient or the patient's agent. There must be a record in a uniform place that documents a patient's acceptance or refusal of counseling and who made the offer to counsel.**

Include a sample of this documentation.

SAMPLE INCLUDED YES ☐

☐ **(13)** **A patient profile record must be maintained for a period of not less than one year from the date of the last entry in the profile record unless it is also used as a dispensing record.**

Include a sample patient profile with this application.

SAMPLE INCLUDED YES ☐

13. **To Comply with the Delaware Drug Product Selection Act:**

USP/DI Current Annual Edition (all volumes and supplements) **YES** ☐ **Year**_____

or

FDA Approved Drug Products with Therapeutic Equivalence Evaluation (current edition and supplements)

YES ☐ **Year**_____

14. **Current Delaware State Laws and Regulations governing Pharmacy** **Yes** ☐

15. **Current Federal Regulations covering the Controlled Substances Act and Regulations (If available in another text, purchase is not necessary)**

Yes ☐

Check references available for pertinent patient information:

16. A. Drug Interactions:

- ☐ **Facts and Comparisons - Drug Interactions**
- ☐ **Drug Interactions**
- ☐ **Hansten's Drug Interactions**
- ☐ **APhA Evaluation of Drug Interactions**

B. Drug Information:

- ☐ **Facts and Comparisons**
- ☐ **American Hospital Formulary Service**
- ☐ **Pharmindex**

17. Medications must be maintained at the USP/NF temperature ranges. Explain briefly procedures used to transport medications that need special handling or temperature monitoring._____

_____

18. Prior to being issued a permit, the Non-Resident Pharmacy must provide the Board with a copy of the most recent inspection report and thereafter must provide the Board with inspection reports within 60 days after receipt from the regulatory licensing agency of the State in which it is a resident.

Inspection Report included Yes ☐ **Date**_____

AFFIDAVIT

19. I certify that this non-resident pharmacy complies with all lawful directions and requests for information from regulatory or licensing agencies of the State in which it is licensed and will comply with all such requests made by the Board pursuant to the Section of conditions of permit for Delaware.

20. I certify that this Non-Resident Pharmacy will maintain its records of prescription drugs dispensed to patients in this State so that the records are readily retrievable from the record of drugs dispensed for other patients.

21. I hereby swear or affirm that all the foregoing statements are correct and do hereby agree to abide by the Pharmacy laws of the State of Delaware, in §§2538, 2539, and 2540 for non resident pharmacies and to the rules and regulations of the Delaware State Board of Pharmacy as applicable to Non-Resident Pharmacies.

Please note: When your application is <u>complete</u>, please allow 4-8 weeks to receive your license. A <u>complete</u> application is one that includes all required documentation and correct payment.

Applications that are not <u>complete</u> within six (6) months of filing may be considered abandoned and discarded. The Board office will attempt to notify you before disposing of an abandoned application.

Signature_____

Subscribed and sworn to before me this _____**day of** _____

_____**.**

Witness my hand and seal hereunto attached.

_____

NOTARY PUBLIC

(According to 24 <u>Del</u>. <u>C</u>. §2531 this permit will expire on the last day of September, biennially, even years. Permits are not transferable.)